MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
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10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Quality improvement for health plans and providers
Karen Milgate, Mary Mazanac

P R O C E E D I N G S

MR. HACKBARTH: I'd like to thank our guests for coming. As always, we will have public comment periods. We will have one at the end of the morning session and another at the end of the day.

Our first topic for today is quality improvement for health plans and providers, a November report. It's November. So Karen and Mary, whenever you're ready.

DR. MAZANEC: Good morning. This presentation will continue our discussion of quality improvement standards in the Medicare program that we began at the October meeting. I will begin by briefly summarizing our analysis and findings and then Karen will discuss the draft recommendations.

Since MedPAC's report is due to the Congress by the end of November, we are asking the commissioners to comment on the content of the draft report and to discuss and finalize the recommendations.

As you recall, in the BBRA, the Congress directed MedPAC to study and report on how Medicare should apply quality improvement standards to both the fee-for-service and the M+C programs. At the October meeting we presented our analytical approach and findings.

To briefly summarize, our analysis consisted of three parts. First, we identified the goals of quality improvement standards and then examined the manner in which they are applied by private accreditors, regulators and purchasers. Next, we analyzed the M+C standards and the QI efforts in the fee-for-service program. And finally, we evaluated the feasibility of applying standards comparable to the M+C standards to each type of plan and provider.

To comply with quality improvement standards, a plan or provider must be able to measure care, improve care by influencing provider behavior, and then remeasure and report on the results of their efforts to improve care.

Based on our analysis we concluded that first oversight in private and public purchasers efforts are duplicative. Private accreditors may have similar but not identical quality improvement requirements as the federal government. Compliance with multiple sets of standards may increase costs without adding additional value in terms of quality of care.

Second, we found that providers and plans have varying capacities to comply with quality improvement standards. Often the structure of a plan or provider will determine whether it can comply with quality improvement requirements. Tightly integrated

HMOs are better able to measure care and influence provider behavior, and thus are probably in the best position to comply with quality improvement standards.

Conversely, PPOs with large, loose networks of providers are less able to meet QI requirements due to problems with obtaining medical record data and influencing provider behavior. While providers, especially clinicians, are in the best position to influence the quality of care, holding providers accountable for their performance on clinical outcome measures is made more difficult because few individual providers treat large enough numbers of patients with a specific clinical conditions. Finally, we found that rewarding or assisting providers or plans may further stimulate quality improvement.

QI standards represent only one way to address quality problems. In our analysis, we noted that public and private sector purchasers are exploring many other ways to stimulate quality improvement efforts. But at present, little information is available on the most effective mechanisms of improving care.

Karen will discuss her draft recommendations.

MS. MILGATE: I wanted to note, first before we went through the recommendations, that they look slightly different than the version that you may have gotten in the background materials. We changed them some to make them more concise. So they aren't exactly that way, but they are the same as the slides that you had received.

We had four proposed recommendations. Two of them addressed ways that CMS could apply quality improvement standards in the future. The second two address other ways that CMS and Congress could further stimulate quality improvement in the addition to the application of standards.

The first draft recommendation is that the Secretary should work to reduce duplicative oversight efforts when applying quality improvement standards. There are several strategies CMS could use to reduce duplication. The first is that before actually developing quality improvement standards CMS should evaluate the extent to which private sector standards already in use will actually achieve the goals that it has for its population. This will lessen the duplication that's built into the design of the standards.

Further, when determining how to apply standards, another way to reduce duplication is through the ability to use private accreditation in the deeming relationship. This is well developed in the fee-for-service part of Medicare, however it needs to be established in Medicare+Choice. It's important to note that CMS is looking towards doing this. They are currently evaluating several accreditor standards to determine whether they're rigorous enough to establish a deemed relationship with those accreditors for Medicare+Choice.

One aspect of applying quality improvement standards that's

not addressed by deeming is the duplication in the number of measures that plans or providers are required to report on. In the Medicare+Choice program, it's really unclear whether it's necessary for Medicare+Choice plans to actually be reporting on the HEDIS measures as well as additional Medicare specific measures that are defined in the QAPI program.

In fee-for-service, the issue is more of a future issue. Many private sector purchasers, as well as CMS, are considering requiring a core measure set to be reported from various providers. So there's a need to standardize those measures so that hospitals and other providers are not necessarily reporting on so many different measures for different oversight bodies.

If there is an attempt to standardize those measures and they aren't able to standardize them, as in meaning using the same measures, CMS should consider whether they should just use those measures in the private sector.

Once the need for additional standards has been determined, the Secretary should take into account the capabilities of providers and plans when developing and applying quality improvement standards. That is recommendation number two. It really comes out of the analysis of the different levels of capacity that providers and plans have to perform quality improvement.

Examples of how this could be done include, in the Medicare+Choice program, to recognize the limits on record abstraction, CMS could allow less integrated plans to only collect data on measures that rely on claims data. In addition, to address the limitations of some plans to be able to measure and improve care, they could either encourage further plans to use PROs more proactively or else possibly even require plans to use the PROs that are out there to assist them to do their measurement improvement efforts.

Another way that this option could play out, to address issues about equity between plan requirements, is possibly to give all plans the option to only collect data on claims data. There's been a significant blurring between types of plans and Dr. Ginsburg talked this morning further about the fact that more plans are going to broader networks. So that might be an option for all plans in the Medicare+Choice program.

In fee-for-service, because the ability to measure and improve care varies widely, particularly by size of the provider, any standards that CMS applies shouldn't be too specific and should give providers discretion in how they actually meet those standards. And to address data validity issues that Mary highlighted in terms of the sample sizes for particular clinical measures, they could just use clinical measures for quality improvement internally however develop more broad measures to look at providers for accountability purposes, such as did the provider put in place specific safe practices? They could use

patient perception measures, those types of measures which would rely on a larger volume of patients rather than just those in specific clinical areas.

The implications of this recommendation are several and I wanted to talk just a little bit about that. This recommendation is designed to obtain the greatest amount of quality improvement for the lowest cost by recognizing the different capacities in plans and providers. It may also address the different levels of quality risks associated with different payment and care management incentives. However, depending upon how strategies are implemented, it may also require some plans and providers to be held to more rigorous standards than others.

The next two recommendations are other ways that CMS could work to stimulate quality improvement that are not standards. Because of the limited knowledge of the effectiveness of quality improvement standards and the limited ability for some plans and providers to meet them, it is also important for CMS to explore these other options.

The first option that we have here is draft recommendation three, that the Secretary should explore ways to reward providers and plans that work to improve quality. There are several different ways this could be done. Actually, Dr. Ginsburg talked about a couple of them this morning. One is simply by paying higher payments to those who improve quality or those who may simply decide to agree to measure their quality. This could also be done in the form of incentives for consumers to choose particular providers or plans.

The second one would be public acknowledgement of those who put in this extra effort or consistently perform higher. Once again, this could be information to consumers to help them determine what providers or plans they may want to choose.

The other way that this could be done, that we saw some evidence in both public and private sector, was to place a lower level of regulation on those who perform consistently well or who put in the extra effort.

The last recommendation is for Congress to instruct and fund CMS to expand quality measurement and improvement efforts. It's very general in how it's written here. What we had hoped to achieve by this recommendation is to recognize the limits of some providers and plans in meeting some of these quality improvement standards and to support and affirm the government role to assist plans and providers in actually measuring and improving care. So to suggest that the PRO program is a solid strategy for what CMS hopes to achieve and perhaps expand that program.

In addition, in many of the conversations we had with private sector folks and clinicians and all types of providers, it was pointed out to us that the weak link in understanding here is really in how to effectively engage clinicians in improvement efforts, and that there needs to be more research on how that

actually should be done, and that that would be another form of assistance to providers and plans, simply to do the research necessary to learn about what are the effective practices and to diffuse the information out into the plan and provider world.

One place to begin here would be to do an in-depth analysis of the efforts and the payoff from the Medicare+Choice quality improvement efforts and the fee-for-service program. Actually in the next six months we're going to start having some pretty good data on the results for the last three years in both programs on how effective their efforts have been.

So those are the draft recommendations. We are, of course, here for any questions or comments you might have and look for some final recommendations.

MR. HACKBARTH: Thank you, Karen. Ralph?

MR. MULLER: One of the questions as we look at quality improvement efforts going forth is to what extent we're looking for these improvements to occur at the provider level, versus the kind of health system level. I think both in your presentation and written material it's very clear that trying to hold providers accountable for care that goes on outside their setting -- since most providers do not have a monopoly of the responsibility for the health care of a person. During acute episodes they might. So it's very difficult, in a sense, to hold them accountable for the whole health status of a person or a population.

On the other hand, some people are looking at measuring health status of populations across time. So I think one thing, it's my conjecture and I won't ask you to comment on it, whether at least for the foreseeable future it's more likely to be able to measure quality of care at a provider level rather than the kind of systemic way that goes beyond providers. And therefore, whether our recommendations should be specific about that, that providers is where we can measure right now even though in the long term we may be wanting to look at more than that.

And coming out of that therefore, on recommendation three, which I think is important but I think we need to stress even more, is right now I think there's a suspicion among some that those who are able to measure are as likely to be penalized as rewarded. Sometimes you're almost better off being a black box that can't be scrutinized rather than one that is open to scrutiny.

So I think some sense that if, as you say, the Secretary should explore ways to reward providers, I think it's important if we want to keep encouraging them to measure the quality which, as you know, is a difficult effort given your many pages to that fact, that we have to be very clear in saying there have to be rewards for this as opposed to penalties for trying to measure quality.

The third point I would make along those lines, and this was

triggered more by some of the comments that were made in the discussion this morning. If one thinks about some of the safety net providers and some of the capacity problems that we're seeing in some of the settings, is it a sign of good quality or poor quality that safety net providers are stacking up in terms of capacity problems?

In one way, if you just kind of look at crude measures, you would see the fact that people are waiting for care and may not be getting the care on a timely basis is a measure of poor quality. On the other hand, it may be an indication that those institutions, those doctors, those neighborhood health centers and so forth are available to take care of a population that may not get it elsewhere.

Again, your discussion points out how difficult it is at times to take any of these measures at face value without understanding them more fully.

So just to summarize, especially on recommendation three, I would urge us to point out that if we want qualitative improvements to go forth, we have to be very clear that people don't get penalized for being part of the measurement process. Obviously, if there's evidence of poor quality there has to be some action taken towards that. But we don't want to have, in that sense, people penalized for being in the forefront of trying to measure quality.

Certainly we see, whether it's by looking at the HMOs versus other kinds of plans or looking at large institutions versus less developed institutions. Right now we're looking for quality improvements to really be in areas that are more developed, as opposed to institutions that are less developed.

DR. NEWHOUSE: I found this a particularly difficult set of questions to deal with. Let me start by saying I think there's a lot of data showing that there's ample room for improved quality. So the notion that the country shouldn't, in some sense, be addressing quality improvement is not an issue.

In terms of the report, although you do distinguish them, I think since I'm going to make some negative remarks about quality improvement and wind up trying to recast recommendations three and four, I would start out by even more sharply I think than you do, distinguishing quality improvement from quality assurance. And say quality assurance has to be a given as the minimal level of quality. So that it's clear that we're talking about quality improvement efforts, as opposed to quality assurance efforts.

On quality improvement efforts, where I'm going to come out is putting together recommendations three and four into research and experimentation with various kinds of incentives, by which I mean both payment and information since public reporting is a form of incentive.

My concern with just going whole hog into this, in addition to what Ralph said, with which I agree, are at least three. One

is many of the measures that I'm familiar with, certainly the outcome measures and many of the process measures, require risk adjustment. That's an imperfect art at best. It also will require auditing the risk adjusters, which is an issue. I think in implementing it would set up concerns about coding of the kinds we've seen on the reimbursement side.

Secondly, I think there's a concern about teaching to the test, in effect. Our measures are better in some areas than others, for example in cardiovascular than in cancer. If I were running an institution and I were faced with a bunch of measures of quality of my cardiac surgery, I would put more resources into cardiac surgery and fewer into the unmeasured areas.

Which implies, by the way, if we're going to do research on this, we're going to have to find out what's going on in the unmeasured areas, which is a real challenge.

The third kind of problem is really a selection problem. Any of the measures that require patient compliance is going to set up selection against non-compliers. For example, the immunization measures. We also know that sample size is certainly a problem at the provider level. There's some very good analytical work on that at the physician level.

So what I would do, as I say, would be to take recommendation three, that the Secretary should explore ways to reward providers and work to improve quality, which is consistent with the notion of research and experimentation. And I would recast four, I think, in that light. I noticed the original draft we got did have research mentioned in four and it's taken out of the slide here.

And by the way I would mention, if we're going to talk about a specific agency, which we do in four, and we're going to talk about research, we should talk about AHRQ as well as CMS. I don't know that we need to talk about a specific agency, we don't in recommendation three.

I guess I'm very skeptical of how much good we can actually do relative to how much harm we can actually do if we adopted relatively potent incentives for quality improvement, again as opposed to quality assurance.

MS. MILGATE: Can I just ask a question back to you, Joe, so that I make sure I understand what you said?

Your point is that you don't think that we know enough to do draft recommendation three by itself, and so the thought is that we need to do more research to understand how we should steer folks?

DR. NEWHOUSE: No, it's really recommendation four that's my bigger problem, where you say should instruct and fund CMS to expand quality measurement and improvement efforts. Whereas three, you say should explore ways to reward providers and plans that work to improve quality.

Well, explore ways has a research experimentation feel about

it, whereas four sounds like much more turn on the juice. So there's a bit of tension between those two recommendations as they're worded. I would come down on the side of three.

MS. MILGATE: Would softening four help that though?

DR. NEWHOUSE: I don't know that you need it.

MR. HACKBARTH: You're saying just drop four?

DR. NEWHOUSE: I think so, or meld three and four together in more of a tentative mode.

MS. MILGATE: So include some of the ideas in the discussion that may be under four under three, which are about assistance and research?

DR. NEWHOUSE: Yes.

MS. BURKE: Glenn, can I just follow up with a question related to this? One of my concerns in looking at the old draft of recommendation four -- but I'm very much in sync with where Joe is. It's also fundamentally the question as to whether CMS is the right place to do all of this, particularly when we get later in our discussion about issues of regulatory burden and things of that nature.

The question is what role should CMS play? And what are we presuming the answer to that being, specifically in this context? Joe raises the question of whether or not AHRQ or somebody else ought not to be involved in this to a certain extent. But I think as we look at these going forward, I'm also concerned about the question as to who and where the capability ought to lie, and who is best funded to do either the research. In demonstrations it might well be CMS because of the population, but I think that is a question that we need to understand. And I don't want to assume that CMS is the right answer in all these cases, because I'm not at all certain it is. I think there are real questions about their capacity over time and how many things we ask them to do.

MS. ROSENBLATT: I was going to suggest that recommendation three be expanded to say that work to improve quality and measurement. So just consider incentives for having better measurement, particularly on the health plan side.

The other comment I was going to make is Wellpoint got a lot of press recently in our efforts to reward providers for quality. It might be worthwhile to have some real live examples of where that's being done in the marketplace.

The other thing is just linking up, as Ralph did, the comments we heard this morning from Paul, he used words like consumer driven, information driven. This becomes so important.

DR. ROWE: Two points. One is I think that we should have some reference here with respect to respondent burden, as Sheila mentioned. We talk about it in regulatory burden and tomorrow we'll talk about Medicare+Choice topics that you have under tab J. It talks about the plans in terms of what risk adjustment data we wanted to put in, the plans want X and MedPAC wants Y, et

cetera. It was clear that the collection of those data was dropped because CMS was trying to find some way to lessen or make the M+C program a little more comfortable for the plans.

So we should at least be mindful of that as we talk about this. Otherwise it will seem disconnected from these other chapters.

That having been said, I think that there's another piece of this which is even more important and which urges Medicare to do this. I think unfortunately, in the health care marketplace with respect to health plans, there has not yet been the development of a significant number of purchasers; i.e., employers, who are willing to pay for quality. They talk about quality but they purchased based on price or other kinds of benefits. But there has not been a very significant movement in the marketplace to pay for quality.

It doesn't mean there aren't some sponsors, and we have some and I'm sure Wellpoint has some and others, who will pay for what they perceive to be quality. But given the fact, particularly with the tight economy, we were talking about defined contribution earlier and other things, that really Medicare is in the position to develop the experiences to see what kinds of quality oriented products, if you will, from health plans in the M+C program might be effective for the members and providers and everybody else.

It really seems to me that in the absence of anyone else stepping up that there is a very significant opportunity for Medicare here to lead the way.

And so from that point of view, I think it might be helpful in the beginning to talk about Medicare's role in the entire health system. We sometimes focus just on Medicare and not talk about the rest of the system. And if we have something about the disappointing lack of free market initiatives in this area, that that would support Joe's idea about some specific demonstrations and things like that. Thank you.

MS. NEWPORT: I have some editorial comments that I'll share with you ladies later, but I guess the emphasis here focuses on -- a little bit of tone, too -- is that there were some formative efforts by health plans to market and start marketing on quality initiatives. That's one of the reasons that NCQA, as well know, NCQA and other accrediting organizations are starting to be utilized more and more to measure quality.

So the early blunter instruments to measure, as Alice would say, have been refined over time and have been used, some of which BBA piggybacked on.

I think that the concern or the subtlety that's lost in this is that we seem to have, because to some extent health plans are integrated systems, the ability to measure more concretely what is being done. And then the struggle is then how do we bridge to the fee-for-service area?

One of the things I don't think we even approach very well is that what impact has plan measurement on provider groups and provider systems had to raise the bar on quality because we are in the marketplace? And I think it would be helpful to recognize it, even though they may not be measuring all of a physician's practice or all of a hospital's care that there are some standards there that intuitively impact on how they perform. Because I don't think they have an on/off switch. I hope not, anyway.

So I think we need to kind of look at this iteratively, that the focus and the emphasis and the delegation of resources needs to then go to a broader level, albeit incorporating tools and techniques that might be more right-sized for that particular fee-for-service area. So I think I'd like to see something more affirmative around that.

Then I think we cannot underestimate the cost in terms of the regulatory burden, that may be justified and cost effective, because it does improve quality, with overbuilt systems or overwrought systems in some cases.

So one of the concerns I would have with maybe the last two recommendations is that we make sure that in the statement that -- we're seeking balance and we're seeking exportation of things that we've learned in one area to areas where, because of the breadth of them, that we haven't had the opportunity yet to devise techniques to have meaningful measurement and quality indicators.

So I think that's it. Thank you.

DR. NELSON: I had a different interpretation of recommendation three from that that I think Joe presented, because he was looking at this in terms of supporting research and experimentation. I looked at this as the Secretary finding ways to reward tools that clearly reduce errors, such as computerized order entry in facilities that 100 beds that would like to do it but they don't have the resources. The skilled nursing facilities that are having greater incidents of bedsores simply because they don't have the resources to put in place the processes that reduce that.

So I would hate to see draft recommendation three diluted. We have to acknowledge the fact that there are restrictions in the ability of facilities to fully take advantage of the science that we know supports the use of certain modalities. And what the Secretary should explore is ways to assist those who are able and willing to incorporate those quality assurance techniques with Medicare paying its fair share of the bill.

So I don't have any argument with having Joe's point expressed, but I would hate to see what I believe you were driving at lost in that process.

DR. STOWERS: Not to digress back to recommendation number one, but to me there's a great discussion about what's happening

in the private sector and in the public sector. I'm just wondering, the way we read this as it stands alone, that when we talk about duplicative oversight efforts that that can get interpreted to just be doubled efforts within Medicare or whatever. And that this recommendation on its own really comes across to say that we ought to be looking at the efforts between the private and public sector. And sometimes these recommendations kind of stand on their own and I don't think that point comes across in the recommendation.

I think the discussion is great.

MS. MILGATE: So you want it to be more duplicative efforts generally because it's not just public versus private?

DR. STOWERS: I think we need to somehow come across in the recommendation come across with the fact that it's the duplicative efforts between what the providers are having to do on the private side and what they're having to do on the CMS side or the public side. That doesn't come across to me in the recommendation, that it could be just doubled efforts within Medicare.

I think somehow we've got to get that point across because I could see someone reading that and saying well, this is one more regulatory or simplification of CMS that we're asking for and not really the broader picture that your text backs up.

MS. RAPHAEL: I guess as I look at this I put in order of importance that, to me if the purchaser doesn't recognize and reward quality, it isn't going to happen. So to me that is the most important recommendation that we can make with the caveat that as you measure quality you don't look very good when you uncover a lot of things that were hidden before. And you don't want to end up being punished because your statistics don't always put you initially in the best light. But somehow the effort of measuring and investing should be recognized and rewarded.

Secondly, for draft recommendation number one, I don't think the issue is activities. I think the issue is that there is a lack of integrated focus between all the people who are surveying and measuring you. They don't all have the same standards, so it isn't just that they engage in different efforts at different times, but it's that they have often completely different standards that you're being judged by. So I think that recommendation number one needs to somehow talk about the fact that there needs to be more coordination of the standards that you're being judged by.

And thirdly, I think that we need to somehow foster more experimentation, whether you call it research, exploration. This is very hard work and we don't know very much. We don't know how valuable this all is, what this will all amount to. So I think we are in an experimentation phase, and I think that's healthy. I don't think we can lock in at this point and say that we know

enough about what works in the clinical care process are, what works in the kind of customer satisfaction and response and access area.

So I just think that somehow one of these ought to capture trying to promote more experimentation and dissemination of results in this field.

DR. BRAUN: I just wanted to mention, in draft number two, I think while we have to take into account the capabilities of the providers and the plans, we also I think need to be aiming for equal protection of the beneficiaries across the Medicare program. Certain plans are being asked to do certain things and others are not being asked to do them. So I think we need to find ways that the protection can be equal for all beneficiaries across the program.

The other thing that I want to mention was I think when we're talking about deeming, it's important to be sure that if this is private accreditors doing the -- obviously, private accreditors -- doing the accrediting, it needs to be a transparent process when it's a public program. I think that's part of being a public program.

MR. FEEZOR: I just I guess wanted to underscore comments Jack and Alan made about Medicare really being able to be in a position of leadership in putting money up, particularly in the rural and underserved and heavily concentrated areas of Medicare enrollees.

Parenthetically, Karen I probably need to, if you're unaware of the effort in California where we're trying to get about five or six major payers together to, in fact, pay for performance under the Integrated Health Association. I don't know whether you've seen the recent work that they're doing on that.

Two other quick comments. I guess I was struck by Ralph's observation that if we believe that, in fact, and certain the retreat of Medicare Choice would suggest in at least the short term that there's greater individual choice is going to be more the marketplace going forward, then that does put the emphasis on our quality measures perhaps going down more at the provider level as opposed to system or PPO level. And yet I'm struck by the paradox that puts us in and the fact that if about 90 percent of Medicare's expenditures and about two-thirds of the enrollees have more than one disease state that they're dealing with at the same time, the difficulty of getting true measures, if you're talking about accountability. So I just sort of put that as a paradox that I think we'll have to be dealing with going forward.

DR. REISCHAUER: One small suggestion. It may not be possible. But in the discussion about duplication, I wondered if there were any data that would say what fraction of nursing homes go through two or three of these procedures or hospitals? Because that might give it a flavor. It might not be available, but it would provide a number here or there.

I have sort of a general observation to make and that is looking at quality it strikes me that there is cost reducing or cost neutral quality improvement. That is if you do the right thing health care costs will go down or they won't rise and the outcome will improve. And a capitated plan should have an incentive to adopt those types of quality improvement measures, although many of them I don't think do, as Alan suggests.

Individual providers who care more about volume don't have a financial incentive. I mean, they have in a sense a moral imperative to do that. So that's one kind of quality improvement. But probably a lot of quality improvement is really cost increasing. It improves health but it costs more.

And it's difficult, under a system like this, to expect providers or plans or whatever to respond. There are some of these instances in which the value of the health benefits exceeds the cost of the quality improvement and some where it probably doesn't. But in either case we have to ask who's going to pay for this? It won't happen on its own.

This really gets to Carol point. Is CMS going to pay for it or are we going to expect the patients to pay for it?

I have, going through these recommendations, problems with rewarding people for improvement as opposed to high level. You know, if the assurance standards are pretty minimal, which they are, I don't want to have a system which rewards somebody for going from a minimal level to minimal plus and doesn't give anything to somebody who is really superior who slips a little in a year but still is way above the other.

You can think of a temporary program to help certain particular entities like rural hospitals develop the capacity to operate effectively at a higher quality standard, but those would be temporary. The reward system and incentives system really should be on high level, as opposed to change.

DR. NEWHOUSE: A couple thoughts on the discussion. One is along the lines of Bob's point about costs. I don't think we know a lot about costs of many of the -- take computerized physician order entry that Alan talked about. We do know something about that reduces errors. I don't think we know much about how much it cost to train the physician staff to use it, how much it costs to maintain it over time.

Maybe it's sufficiently costly that you can't afford to do it at every hospital. I don't know. But I think that's something that would need to be looked at before we had a requirement to put it in everywhere.

The second point goes to Bea's point about equality. I think that's almost inherently impossible. One of the places we know where there's a problem is handoffs from one provider to another. This goes back to the point Ralph made earlier. That's almost got to be there in the traditional plan and in private fee-for-service as well, because it's kind of nobody's business.

In the health plan world one could conceptually hold the plan accountable for handoffs. But if one does then that's, by definition, asymmetric from the point of view of the beneficiary, which gets you into an issue of how do you handle the symmetry.

DR. ROWE: Reaction to Bob's comment. I think it's very good and I think we should pay attention to it here. I think it would be helpful to have a section early on in this chapter, which is really excellent, that talks about the relationship between quality and cost. Because we don't go into that and there is a lot of basic stuff there but we just sort of dive into improving quality. Make it explicit.

You might consider using the traditional analysis of Chassen, that there are three kinds of quality problems. There's overuse, underuse, and misuse. And if you get rid of overuse yes, that does save money. But if you get rid of underuse, which is particularly a problem in gender-related areas like heart disease in women getting less treatment, or in racial and ethnic disparities in treatments, that costs more. It's good, you get more quality but we should understand what we're in for.

And correcting misuse, there's a cost associated with the identification of misuse and correcting it. It could cost more, it could cost less. But some sort of structure like that I think would be helpful because it helps to align the incentives or disincentives associated with the various changes in these different models, such as a capitated model, et cetera. I think that that might be helpful.

And you might reference the IOM report, which is not referenced here.

MS. MILGATE: It will be.

DR. ROWE: And talk a little bit about their approach.

MR. DEBUSK: I just have one comment to make on automated order entry and these sort of things. That's inexpensive, simple. That bear has been crossed in the medical profession for a long time. We deal with that constantly. And that's lacking.

You talk about this quality thing and you think of how are you really going to improve quality? And if quality systems are implemented, costs should go down. I agree with you very much on that. But in the field of medicine, the protocols, the clinical pathways, these things are what we really need to be working on to better describe these, put them in the system, and then process control, production control, break them up into parts and evaluating them on that basis, and then look at your outcomes, your production.

We're way back on the whole process of what quality is all about. It's good to talk about it but probably we should visit industry a little bit and see what they're doing about some of these things because we're in the production business in patient care today. It's just so archaic how we do some of these things and we talk about these things.

Can you buy quality? Can we do what we're trying to do? I don't believe we can.

MS. ROSENBLATT: I just want to address the point Joe made about consistency across fee-for-service versus HMO or health plan because at Wellpoint we have actually been trying to figure out how can we measure quality for our PPO members. Our technical people and our physicians got together and came up with a very simple way of measuring something like compliance with mammograms and pap smears.

The idea was if a woman sees five doctors and she gets her annual mammogram then all five doctors are said to be that's okay. Because maybe one asked her -- if she went to her general practitioner and she had had the pap smear with her gynecologist and the general practitioner said have you had your pap smear and the answer is yes. Well, then obviously the general practitioner did not have to do it.

So I do think there are simple ways of doing that, and that we need to just take a new approach to thinking about how we do those things so that we can measure it in the fee-for-service world. And I think again, just coming back to the comments made this morning, consumers I think are ready for this type of information.

And Medicare is the 800-pound gorilla and I am strongly in favor of Medicare trying to do all types of things, even in a fee-for-service world.

MR. HACKBARTH: In listening to the conversation I hear broad agreement on at least two basic points. One, that this is important and it would be valuable for Medicare to be a leader, so far as possible. And two, that this is a developing field and there are a host of very complex issues having to do with measurement and risk selection and so on.

The conclusion that I personally draw from those two points, which I agree with, is that we ought to be looking at encouraging voluntary efforts in quality improvement. We don't know enough to be mandating this or that be done. I think that should apply across all sectors.

That's the approach, as I understand it, now being taken in traditional fee-for-service Medicare. We try to encourage quality improvement measurements using the PRO structure. I think that is also the approach we ought to be taking with regard to private health plans and M+C so that we do not impose a burden, an unequal burden, on one of the competitors in the M+C system that we've established, particularly when we know so little about this developing field.

So I'd like the tenor of the report to be great, important stuff. Let's do it, let's encourage it, let's finance, research, et cetera. But let's be wary of what we don't know and let's not tip the balance in the M+C competition by mandating something for some competitors but not for others.

DR. NEWHOUSE: Aren't those two linked? In other words, if you're going to encourage it, however you're going to do that, you want to learn something from having done whatever happens out there. So since it is a developing field, I think you want to link your two points.

MR. HACKBARTH: Say a little bit more, Joe.

DR. NEWHOUSE: This goes to your point about we want to encourage voluntary improvement. Well, we want to encourage voluntary improvement but we want to learn something about the efforts that various factors undertake to improve quality. Maybe we want to induce them to undertake those efforts by doing some formal kinds of experimentation and paying them for that, to see what happens.

But however it's done, if it's just exhortatory or if it's more than that, we certainly want to learn something about the effects of this, with the hope that we can then generalize from that, whatever it is that's going on out there.

MR. HACKBARTH: Could I just clarify one point? I have some concerns about the wording of draft recommendation two, which at least as I read it says that you might require some organizations to do something because they have broader capabilities or enhanced capabilities that you don't require other competing organizations to do. And I think that actually is counterproductive.

I think that that tension, given how little we know about this field, we could be handicapping organizations that are trying to do the right thing. And that's just not what we want to do at this point. So I don't want to say well let's put burdens on people in accordance with their capabilities. Let's try to encourage everybody, fee-for-service, various type of private plans, while we are still experimenting and learning about this complicated field.

DR. NELSON: I'd like to take your synthesis just one step further though, in terms of the Medicare program being more than just an interested bystander in this. I'm probably mischaracterizing where you're going, but nonetheless, I wouldn't want someone to interpret our position as being passive about it.

That's the reason why I like the idea of the Secretary exploring ways, maybe through demonstration projects or some other way, to see if incentives can be built in that actually promote quality improvement. I can live if it's not among our recommendations. But I wouldn't want us to come out with a report that was interpreted as being passive when there is an opportunity for the Medicare program, along with business and others, to actively promote, through the use of incentives, quality improvement.

MR. HACKBARTH: Just for the record, I don't want people to interpret what I'm saying as being lukewarm about this. I do think it's important and I would like to see Medicare be a

leader. But I wouldn't like to see us respect what we don't know about how to do this.

DR. ROWE: I think I was going to make the same point Alan did. I thought I heard, in your comments and in Joe's, a general interest in avoiding disadvantaging some elements, and at the same time exhortation to cheer on people who wanted to work in quality. And I think we've been doing that a long time with no effect. We really need to put some incentives in to see if that will make a difference. So I would cheer them on with an incentive in these specific demonstrations.

And I think we should put that specifically in the report, that on a demonstration basis is not going to significantly disadvantage other elements that don't have the capacity to respond to the challenge. It might stimulate them to develop the capacity.

DR. REISCHAUER: Just judging from CMS' behavior over the last few months, it's clearly desperately looking for ways to pump money into managed care organizations. And an aggressive demonstration initiative, tied to quality, I think is the most defensible way to do that. And it also serves the purpose of allowing us to learn something, both about what's possible and where the limits might be.

I was going to mention something else about different standards for different types, but I won't.

MR. MULLER: This is consistent with the last few comments, but in light of what we'll be discussing the rest of the day in the session where we will be talking about cost concerns and updates and physician payments and so forth, having the quality agenda, the cost agenda, and then obviously -- as was referenced in the comments this morning -- given some of the cost pressures that are going on in premium increases, more and more people are likely to get uninsured in the near future.

We have to be looking at to really encourage the kind of quality improvements everybody seems to be talking about, there have to be the kind of incentives that a number of people just mentioned.

I would also point out, just listening to the comments over the last hour, I would say the ways in which people approach the quality discussion is probably as varied as any discussion that we're likely to have. And people really come to it in so many different ways, which tells me that nobody is even close to a consensus as to how to really improve quality. I think that's consistent with Joe's comments earlier.

So therefore, a strong sense of experimentation, a strong sense of reward for that kind of experimentation, but also I think a sense of caution that this agenda is not moving forward anywhere near as quickly as other agendas because it's so complicated and likely to stay complicated for a long period of time. So I don't see a likelihood of any major breakthroughs on

this.

This is as apple pie as it gets, you're supposed to be in favor of quality in health care. But just to reference one of Bob's questions earlier, who's against in a sense rewarding people who are doing very well? But look at just one of the common HEDIS measures. Are we better off as a community if you get immunization rates in some tough areas up from 15 to 50 or better in some homogeneous area getting it from 75 to 90? One can debate that considerably.

But some of the real problems in this country, something as simple as that, are getting the rates from 15 to 50 in certain of our populations and so forth. In some ways, not to belittle the difficulties of some more affluent homogeneous areas, tweaking it from 75 to 85.

So again, heavy on experimentation, heavy on the incentives, but also understanding this is going to compete with some other agenda that we're going to be talking about in the next 24 hours.

MS. BURKE: Just one cautionary note. I don't disagree at all with the direction you're going and I think we ought to acknowledge that there are things that we don't know and we ought not be requiring things of plans or individual providers that we are uncertain of. And I think all of the efforts at demonstration make a great deal of sense.

Having said that, I would be very concerned if the message that came out of this that we were any less committed to an expectation of requirements over time, that in any way we suggest that over the long term that this is going to continue to be some kind of a voluntary system, that there will be no explicit expectations on the part of the major purchaser of what it is that we expect providers and plans to do.

And I wouldn't want us to suggest that we're backing away from the requirements already in statute, or that we don't anticipate that once we have the information in hand and the capacity to encourage or incentivize providers to do certain kinds of things that we won't use those to put in place some fairly clear expectations as to what plans and providers ought to do.

So while I agree we ought not put in place things we don't know how to do, I don't want to suggest that over time, once having established those things, that we are any less committed to expectation that plans and providers will, in fact, comply with some kind of standard.

MR. HACKBARTH: The existing law in fact requires -- has differing requirements. You said you don't want to see any backing away from the existing differing requirements?

MS. BURKE: I don't want us to appear to be stepping back from A, the current statutory requirements, acknowledging that there are differences, that there were exemptions of non-HMO plans in terms of what was required of M+C plans. My point is

simply I don't want us to suggest that we are backing away from an expectation of a system that will expect certain kinds of behaviors on the part of plans and individual providers that we don't yet know today what we need to know in order to know what those expectations ought to be, or how best to measure.

So I acknowledge that we don't have enough information today to put in place a whole series of new requirements. But I don't want to suggest that we are unwilling to do so once we have the information in hand, or that we are any less committed to quality being critical in terms of our purchasing decisions going forward.

MR. HACKBARTH: The last part of that I feel entirely comfortable with. It's the first part, the unequal requirements that exist in current law, which makes me uneasy.

MS. BURKE: Right. So are you suggesting repeal of the statute to deal with that?

MR. HACKBARTH: I'm certainly suggesting a change in the statute so that we would say that we ought to have equal requirements across the sectors. There might be varying requirements at some point in the future once we know more about what the right thing to require is. I don't think that the current law has struck the proper balance.

MS. BURKE: So as part of this recommendation are we suggesting a repeal of the statute or a modification of the statute? Is that what your expectation is?

MR. HACKBARTH: Maybe what we need to do to really nail this down is actually go through the recommendation language that we would be talking about. Why don't we put up the first --

MS. BURKE: Because I didn't see that in any text that I read.

MS. MILGATE: Can I just say a couple things that may help us come to some middle ground here on this? The difference in statutory requirements between HMOs and non-HMOs, in terms of how it's played out in the regulatory realm is primarily just one thing. And that is that the non-HMOs don't have to demonstrate improvement on this extra QAPI project. That's for reasons that we talked about.

I wanted to just point out the distinction between the standards which require plans and providers to put processes in place to do QI and then the other whole set of measures. That's actually where there's much more controversy, as you have all talked about, the uncertainty about what you're measuring, how well you're measuring it, whether what you come out with actually makes any difference.

So one way to approach the equity issue would be perhaps to suggest there should be equity in establishing processes to try to improve, but then pay around with how much extra is required in terms of measurement. Because that's where the real lack of knowledge is and where it becomes much more difficult to actually

compare plans with other plans, providers with other providers, because they're so different and have such differing levels of ability to actually measure and report on what they've done.

DR. ROWE: I don't know whether or not the people who drafted the statute had this mind, but it seems to me that the way the elements of the health system have evolved that are involved in providing or organizing or paying for this care, that different elements have very different structures and functions and inherently different capabilities. And I think there is a difference between equity and equitability here, that we may not be able to get equity and be fair because we would be disadvantaging some elements that just are not organized in such a way as to provide the information or have the control over the providers, or whatever. The difference between a tight HMO and a PPO, for instance, is the reason why NCQA can accredit a tight HMO reasonably well but it's much harder with a PPO because the plan has much less control over the providers.

So I think in our search for an improvement in the effort to gain and enhance quality, I don't want us to disadvantage anybody. So what I hear, and this is new to me, is that the reduction to practice of the statute really only gives us one distinction which does not seem, to me at least, to be an unreasonable distinction.

So where I come out is that we probably don't need to modify the statute. What we need to do is emphasize that the way it should be applied should be such a way that mindful in the differences in the elements of a health system, they should all be accountable for quality and none of them should be passed over with respect to this. I think that's the message.

DR. NEWHOUSE: I think we all agree that the inherent capabilities are not the same. So my point is that to the degree we go on from that to say we would require different things, and to the degree those things have cost implications then reimbursement also has to be unequal.

MR. HACKBARTH: What you don't want to do is create a system where people say boy, I don't want to develop any capabilities because then they'll have expectations of me. Disavow any responsibility for anything and keep my capabilities at a minimum because then they leave me alone.

MR. MULLER: That was the discussion we had earlier about if we improve quality in the system why not reward people for doing so. And given the kind of concurrence through the last through moment's discussion, that there are different capabilities inside the system and likely to be for a very long time, if not forever, inside the system, one wants to encourage those institutions -- by and large institutions -- who have capabilities to use those capabilities in advancing quality.

As opposed to something as perverse as either saying we'll penalize you for it or we'll demand that you have costs added to

your system but we won't pay you for that because we can recognize you, we can deem you, we can accredit you, we can give you conditions of participation and therefore we'll hit you with all those things. But by the way, there's no reward on the reimbursement side. That's truly perverse.

I think it's very difficult to use the kind of equity equitable argument that Jack and Bea have raised to assume that all parts of the system, whether it's providers, plans and so forth can somehow act equally. That's just not a reality.

MR. HACKBARTH: That's right.

MR. MULLER: On the other hand, one wants to encourage us in a powerful way and it does get to costs and change in behavior that we're trying to encourage.

So I think in terms of the recommendations, I would state the varying capacity recommendation in a positive way by saying where these varying capacities exist -- and some of them have already been acknowledged by having the HMOs versus the non-HMOs have the BBA requirements -- we should encourage and reward and learn from those kinds of things, as opposed to going backwards on them -- which I think is Sheila's point in part. But definitely it would be truly perverse to have institutions that are capable of improving quality and be penalized for doing so, either in terms of increased regulatory requirements, scrutiny, costs, disadvantage and so forth. That would be a very perverse outcome.

MS. RAPHAEL: But I think the flip side of that is not to let anyone off the hook. Because I don't think we should be saying that there are some providers or systems that don't have the capability and therefore somehow they don't have to adhere or try to reach certain standards.

MR. MULLER: If I can just, Carol, I think one of the assumptions in all this, I think, is that sooner or later the quality -- like it does in other sectors of the world -- will be recognized and rewarded. Now it may be so far off it won't happen in our lifetime.

But I think one of the reasons, and not just in terms of professional ethos and concern that people try to improve their quality, is in fact there will be a reward for it in the longer term to being a better provider of services. So to that extent, there should be self-regarding behavior that causes institutions, providers, doctors, et cetera, to try to improve their quality.

DR. ROWE: I think we can handle this pretty easy because I think we're at kind of risk for a crisis of agreement here, that we should recognize that different elements have different structures and constitutive abilities that does inherently differentiate their capacity to do certain things. A fish just can't develop lungs and walk out on land. It doesn't have the genome for doing that. We can't punish it for not doing that. That's just the way it is.

On the other hand, what we should do is say that given the differences and the capacities of the different elements, each of the elements should do whatever it can, given its capacities and its structure, to improve the quality of care. And that different elements will use different pathways to get there.

I mean, I think we want to distinguish a constituative genomic aspect of this from the fact that we don't want to go where Glenn was suggesting we don't want to go, which is people will not develop capacities because then they will have expectations placed on them. We want them to develop those capacities within the framework of their entities.

I guess a paragraph about that might then be helpful.

MR. HACKBARTH: I think the only way we can bring this to a conclusion is to actually talk about language of recommendations. So what I'd like to do is go back through those one by one.

DR. NELSON: Glenn, I think it would be helpful if draft recommendation two was rewritten and brought back to us in the context of this discussion, because this discussion changes the tone quite a bit and puts more emphasis on the -- acknowledges the differing capabilities but puts more emphasis on an ultimate goal of everyone being accountable for improving their performance.

MR. HACKBARTH: I agree that it needs to be rewritten. The process will be, we need to provide enough direction to Mary and Karen that they know what to bring back, or think they know what to bring back. That's what I want to make sure of. And then tomorrow or sometime later today we will actually review a redraft. But let's quickly go through.

Draft recommendation one, I think I heard agreement. We won't vote right now.

MS. MILGATE: I heard two changes. Would you like me to cite them?

MR. HACKBARTH: Actually I'd like to not spend additional time right now. Recommendation two, the key points that I think have come up is that we don't want to unfairly burden organizations in the competition, but we want to encourage the development of capabilities which may vary according to the type of organization it is. So it's encourage as opposed to uniform mandates.

DR. ROWE: This sounds like a little too much of a cop out here. What we want to do is add something to this recommendation that says mindful of the differences, we want to require each element to enhance quality to whatever degree it has the capability of doing so. Something like that.

MR. MULLER: Mindful of, we should encourage and reward.

DR. NEWHOUSE: I think there has to be something about reimbursement.

MR. HACKBARTH: To me that's the rub. If in fact there are different costs attendant to these different approaches, then you

start to unfairly handicap one party versus the other in the M+C competition. And so I think you need to have more of a reward mentality than a mandate mentality.

DR. ROWE: Particularly given the current of the M+C competition.

MR. HACKBARTH: Which is critical context for this. This is not a program where we have private plans flocking into it.

DR. ROSS: As we're trying to stitch together these walking fish of Jack's, does that mean we bring together the discussion on recommendation two and pull in number three on that?

MS. BURKE: I guess my impression is two is not specific to creating [inaudible] three and four. I saw this as a different issue, which is the acknowledgement of the differences between the plans and looking at what the expectations ought to be. I think what Murray's saying, at least what I hear you saying, is the issue of the incentivizing and the development of systems to look at different methods for encouraging behavioral changes is an issue, I understood, in three. I understood this to be a different question.

MR. HACKBARTH: So you see them separate?

MS. BURKE: I guess I understood their points to be somewhat different.

DR. ROSS: I guess the problem is I hear the different discussion on recommendation two is I'm hearing two thoughts that I don't think are mutually consistent. The thing that possibly squares the circle here is to bring in the reimbursement rates. That's what I was looking for.

MS. BURKE: Right.

MR. HACKBARTH: The Congress asked us, should they require the same thing of all the different sectors. And I think we have agreement that the answer is no, we shouldn't require the same of all these different sectors because you can't. And so then the next question is well, should we require variable things or should we have a reward mentality that if people invest in improving quality we will support -- help them pay for it through reimbursement, whatever?

And I think that's where potentially we have disagreement. I'm saying I think that we ought to have the reward/support mentality and not let's require things of different people because of the competitive consequences.

DR. NEWHOUSE: Maybe the way out here is to talk about require in the context of quality assurance and reward in the context of quality improvement.

DR. ROWE: Or innovation. I think that that's -- because we don't want to say that if you don't want to go on the pathway of getting extra reward for improving quality, then you have no responsibilities with respect to delivering quality. We don't want to go there, right?

MR. HACKBARTH: There ought to be a quality assurance

minimum required.

DR. ROWE: And that standard might change over time, right?

DR. REISCHAUER: But if you have the same quality assurance standard across all delivery systems, isn't that as far as you want to go?

DR. ROWE: It's not as far as I want to go, but I'm well known to be way out anyway.

DR. REISCHAUER: So you would have different assurance standards for different types of --

DR. ROWE: No, I would have assurance standard across the board for anybody who's involved in providing or paying for care for a Medicare beneficiary. And then I would have an added reward for innovation and enhancement to quality.

MS. BURKE: Can I make just one side note, going back to the old days of a staffer? It seems to me the first recommendation ought to deal with the question. If the question that we were asked is should we apply the same thing across the board, if our answer is no, that ought to be the first thing we say. That's the question. If we have the answer, we ought to agree that's the answer and we ought to say it.

And then we have all these other things. But are we agreed that the answer to the explicit question that was asked is no?

MS. MILGATE: But there was also a question of how.

MS. BURKE: I understand, but nowhere in these four recommendations do we answer the question.

DR. NEWHOUSE: I think it's no, but if you do it anyway then you should reimburse differential.

MS. BURKE: Right. But it seems to me the first thing we need to do is do we have an answer to the question as asked? And if we do, we ought to state it. And that ought to be the first thing we say. And then all the modifiers, if you do, how you do, what you do, and if you want to do something else.

But there was a question asked, do we have an answer? Are we agreed? It ought to be stated.

MR. HACKBARTH: Just to maintain some semblance of schedule, what I'd like to do is have Mary and Karen come back with some recrafted recommendations, and we'll help you do this. There may actually be two conflicting recommendations that capture what I think is a difference of opinion here, and then we'll do that tomorrow around 10:30 or so.

This has been a very helpful discussion for me, and thank you, Mary and Karen, for all the work on the paper. It was well done.

Agenda item continued, Friday November 16

MR. HACKBARTH: What we're going to do now is return to the subject of quality improvement for health plans and providers. As you recall, yesterday we left the subject without voting on recommendations. We asked Mary and Karen to try to capture the essence of the discussion we had in some alternative recommendations which they're going to present now. We can have some brief discussion and then proceed to a vote.

MS. MILGATE: As you remember, yesterday we were discussing four draft recommendations. Just to let you know what you have in front of you today, we came back with two options for the recommendation where there seemed to be some differences of opinion. And we hope that one of the two options represents at least what your opinion may have been on it.

Then the other three recommendations are not significantly changed. Glenn, do you want me to go through the first options first? Or do you want to go through the options that don't have as many changes, first?

MR. HACKBARTH: Why don't we focus our efforts on those first couple where there is an issue. You may also want to mention how you responded to Sheila's point about the --

MS. MILGATE: Putting one first, versus the other.

Yes, what you'll find, first of all, is that we changed the order of recommendation one and two, so that the Congressional question of how to apply quality improvement standards and the issue of the comparable standards is actually addressed in the first recommendation, whereas yesterday we had the one on duplication of efforts first.

So you'll see that there's option one and option two for recommendation one. And then we go through the other recommendations.

I wanted to just very quickly summarize a little bit of what we heard yesterday to identify a few of the issues, and then just go right into the recommendations. Yesterday I think we heard basically three competing beneficiary needs voiced in a variety of different ways. It seems to me a good way to look at the first two options is to think about how those beneficiary needs are addressed within those options.

First is a beneficiary need for high quality care. So just a general support for that as a concept.

Second, a beneficiary need which Bea brought up on equal protection across plans and providers in geographic areas. And of course, that's kind of the heart of the issue that folks discussed yesterday, is whether it's really appropriate to have different levels of standards on different plans and providers.

And then thirdly, a beneficiary need for choice. So that gets at the issue of you don't want to have the standard so high that, in fact, it restricts entry into the Medicare program or

makes it extremely expensive for those certain types of plans or providers in the program to stay in the program.

So turning to the slides, the first option recognizes the discussion that, in fact, there should be some differences in how quality improvement standards are applied. That was a recommendation we had yesterday, but it has the added piece of suggesting if you do that, there should be some kind of reward or compensation for that. So this option -- and let me just read it -- is that the Secretary should take into account the capabilities of providers and plans when developing and applying quality improvement standards. If this results in an uneven level of quality requirements, Medicare should compensate plans and providers who incur additional costs.

So theoretically, that addresses the flexibility issue and says if, in fact, that means there's higher requirements you should compensate those who incur additional costs. Practically speaking, there are clearly some problems with implementing this. If you're talking about payment differentials, you'll have to figure out how much cost you're actually incurring. You would end up probably having to do that on an individual basis because we have so much heterogeneity in the HMO market, in particular.

However, there are possibly other ways to reward. You could use public acknowledgement or lower levels of regulation. So those might be two ways to mitigate that.

The second option basically speaks to the point that some made that we really don't want to have an unlevel playing field between plans and providers, and said let's just put in place a minimum level of requirements on everyone. And then if we go beyond that Medicare would, as in many ways they do in the fee-for-service program now, assist plans and providers and then also reward them in any further quality improvement efforts.

So option two reads, all plans and providers should be required to meet basic quality requirements. Medicare should reward plans and providers whose voluntary efforts exceed minimal requirements.

The implications of this recommendation are several and depends, in many ways, on how you would define basic quality requirements. If, as the discussion went in some ways yesterday, you would define those as quality assurance requirements, it could imply that you would want to repeal the quality improvement requirements that are currently on Medicare+Choice plans and might affect the fee-for-service efforts to actually put in place some minimal quality improvement standards on providers.

If you were to suggest there would be some basic level of quality improvement requirements perhaps just process and structure requirements, but not all this large number of measures or type of measure and specificity of measures. Then it's a less of a -- for want of better words -- dramatic change from what's currently being done in Medicare+Choice as well as in the fee-

for-service program.

So it would probably imply pulling back on many of the requirement measurement efforts in Medicare and perhaps fee-for-service doing pretty much what it's doing and allowing room for them to put in place quality improvement process and structure requirements.

Those are the two options.

MR. HACKBARTH: Comments on those options?

DR. WAKEFIELD: On this recommendation, since it's up there right now. Actually I had a question about -- and you addressed it. But it makes me wonder, I guess, if this one were to pass, if we should have some discussion in the text about what we mean by basic quality requirements. Because the first thing I thought was well, what do we mean by basic quality requirements? Are we talking about QA and/or QI? And basic in both areas or not? So in other words, if this passes I think there's got to be some definitions drawn in the text.

Secondly, am I understanding this correctly that what this could do is to decrease the QI requirements on M+C now down to, if you'll forgive that, but down to what we've got existing in fee-for-service now? As opposed to trying to move QI forward and bringing fee-for-service up. Now that's a really crude way of describing this. I apologize. I wasn't in the discussion yesterday.

MS. MILGATE: In terms of requirements I guess I would say at least that's how I would interpret it. But there was a lot of discussion yesterday on ways to reward providers and plans to actually do more than that. But in terms of requirements, that would be my interpretation, that yes you would be taking the level of actual standards down to -- if people don't agree, I'm perfectly happy to hear otherwise.

DR. ROWE: I thought I heard something different than that yesterday. What I thought I heard -- I mean, we all heard a lot of stuff. One of the things I heard, although it may not have been the consensus, was that recognizing the differences in the inherent capability of different structures, that there would be a different requirement for the basic quality program in the different elements of the Medicare program, Medicare+Choice, traditional Medicare or whatever.

And that above that, all of them should be rewarded for innovation in advance. But that we wouldn't want to put requirements on one that it couldn't reach because it just didn't have the structure or the network or something like that. So that's what I thought were going for.

MR. HACKBARTH: That's option one was designed to capture that point.

MS. MILGATE: Yes, I was just answering option two.

DR. ROWE: I heard something different than you did.

MS. MILGATE: I think what you just said was said. I don't

think it was said by those that felt more comfortable with this option.

DR. NELSON: I really hate to get into the business of rewriting this, but I think you separated the concepts in a way that there's some mutual exclusivity that wasn't reflected in yesterday's discussion. Option two can be fixed very easily to incorporate the idea of different capabilities with just adding a little bit of additional words.

Working from option two and saying all plans and providers should be required to meet basic quality requirements, taking into account the capabilities of providers and plans, which you use in option one. So that variable capability is acknowledged, and should be.

And then the second part says Medicare should reward plans and providers whose voluntary -- and I'd add quality improvement efforts -- exceed minimum requirements. Because you've already talked about quality assurance in the first sentence.

So a combination of one and two, in my view, is necessary in order to accommodate the discussion that we had yesterday.

MR. HACKBARTH: I think I may be the instigator of this problem so let me just take a minute and try to explain, hopefully more clearly than yesterday, my thinking on this. Number one, I think it's clear that by design the quality improvement capabilities of some organizations are different, if not weaker, than others. In fact, there are some types of plans that are designed to take the responsibility for decisionmaking away from the health plan and put it in the hands of individual clinicians and their patients. That's their intention. Plan doesn't control quality, doesn't control clinical decisionmaking.

A second important point from my perspective is that plan level quality information -- I'm thinking now from the perspective of a beneficiary trying to choose among the myriad options that they might face -- plan level quality information is inherently, I think, of very limited value to that decisionmaker when you're talking about plans that have virtually all-inclusive networks.

If you have a plan that encompasses all providers, what Jack referred to yesterday as managed care lite, the differences among plans and their quality are not going to be very great because they're basically using the same providers. It tends to wash out differences. So if we're thinking in terms of helping beneficiaries make decisions, these big network plans reduce the utility of plan level activity.

I think the plan level requirements also have a major cost from a provider perspective. Put yourself in the position of a provider that contracts with four or five different health plans that now have quality improvement mandates that they're all tackling in a different way. And so they've got this bureaucracy, this regulatory burden if you will that's created by

trying to help different plans meet mandated quality improvement requirements when they participate in multiple networks.

This, to me, is grossly inefficient. And as I say, it's of little added value to the beneficiary.

Finally, as I said yesterday, it seems really perverse to me to say well, if you have greater capabilities we're going to put more weight on your back because what that does is create an incentive for people to say well, I'm going to disavow responsibility. I don't want to develop capabilities to improve quality because they're just going to make me carry more weight.

So I was the one who was saying let's get out of this. Oh, we're going to be flexible based on plan capabilities because I think that it's perverse in the incentives it creates and the value to beneficiaries is minimal and it's really burdensome to providers that participate in multiple networks.

And on top of all of that, I think we know this is still an embryonic field, quality improvement. It is rife with problems. Measurement problems, risk adjustment problems, how you engage clinicians meaningfully in quality improvement. I think that mandates, especially uniform mandates or even variable mandates, are just going to get us in a peck of trouble here.

And so I was the one who said yes, maybe let's back away from current law and say in recognition of the competitive playing field problems, in recognition of the inherent difficulty of this field, we ought to be trying to support, reward, encourage quality improvements by providers, whether they're in fee-for-service Medicare or in a managed care plan of whatever type.

DR. NEWHOUSE: I'm sympathetic to that view, and I kind of started where Mary started, that recommendation one has a quality improvement flavor about it and recommendation two or option two has a quality assurance feel about it. I think we would help ourselves to distinguish those. I'm with Glenn that quality improvement, it seems to me, it will be successful if it's voluntary or comes from within the organization, professional motivation and so forth.

Mandating quality improvement, I'm not sure is going to be very successful. Maybe there's some evidence on that. I don't know.

So that would be the general approach I would take with quality improvement. I don't know if that rises to a recommendation or not.

In the quality assurance front, insofar as this is concerning plans, I had a couple of points. First of all, it seems to me the plans value added is likely to be greatest in the coordination across providers area. That the plan has kind of the least leverage within provider, but the handoffs and so forth is where it could potentially add value.

Secondly, I would set the bar for the plan, if we're going

to do this then, I mean minimal requirements is fine but I would like to compare it against traditional Medicare. It seems to me that that's the right -- at least if we're talking about value added -- that's the right comparison as opposed to an abstract standard. But there's some minimum abstract standard also, that really should be there.

DR. ROWE: I think we're backing off a little too far. I'll take my health plan CEO hat off and put my geriatrician hat on here for a minute. I think that, as we said yesterday, because of the lack of incentive from employers -- but we'll get to that change, maybe we'll get to that in a few minutes -- there's not been the development of quality oriented products, if you will, in the commercial managed care marketplace.

Medicare has a great opportunity to really incentivize, foster innovation, reward it. I think that's great. But I do think that -- and notwithstanding the hassles of managed care lite and physicians having to report to four different managed care plans and four different times of the year and four different HEDIS variant measures, et cetera -- and we're trying to work on that, by the way. The industry is trying to, with NCQA, is trying to develop an approach to that.

Notwithstanding that, I think that the promise of managed care is higher quality at lower cost, more prevention, et cetera. And that's what M+C should be. And we should be held to some higher quality standard than traditional Medicare because that is the promise.

I don't know where to go. When I'm listening to you and Joe, and I know it makes sense, it's logical, it just sounds like backing up a little too far for me and I'd like to have some hurdle there for quality as the standard in the M+C, recognizing innovation and reward.

MR. HACKBARTH: Is the only way to show support and leadership a mandate, I guess is what it boils down to? Are there other ways that we can show leadership?

I agree that Medicare should be a leader in this. Do we have tools in our box other than well, let's require it?

DR. ROWE: I understand what you're saying and I think you understand what I'm saying. If there's enough innovation there and if there's a meaningful reward, then we'll get the result, I think. But I'm concerned that there might not be. And the purely voluntary piece of it scares me unless there's a real incentive because we've seen purely voluntary not work in the absence of incentives.

MS. NEWPORT: I confess, like others, to be a little startled with the idea of backing off the M+C standards, frankly. That wasn't what I thought was happening in the discussion yesterday.

What I wanted to convey through our report there was an interest in addressing some of the issues also on the fee-for-

service side right-sizing the standards. I think Bob said it best yesterday, which was not seek a minimum of best practices but incentivize, encourage an atmosphere where more dynamic quality improvement standards were put in place.

So while the intuitive to that is a base, I believe, I was very concerned with -- and Mary can probably speak better to this, that on the fee-for-service side, which is where the bulk of our Medicare beneficiaries are, that as a purchaser Medicare needed to seek a method to export best practices or measure. I think Alice said that yesterday. Measure or confirm that indeed best practices were out in the fee-for-service area as well. Intuitively they probably are to some extent.

But if you're going to be comparing or provide tools for beneficiaries to compare where they should be and be assured that they're getting good quality and the government is paying or they are paying for good quality, that's what we're trying to do. So it was taking this, evolving it into a higher form of quality for a very large purchaser.

So I just don't want to convey the message that we're somehow seeking to take a backward step on this, but encouraging and incentivizing. I don't know how we bridge this at this point, but that's my view. I really think what Bob said yesterday was what I was very comfortable with.

MR. MULLER: I'd like to make my effort at the exegesis of these quality of care standards. Just consistent with what all four of you who have spoken have said. In between things like conditions of participation and accreditation and so forth, there's a basic level that some entities have gone through. Obviously, the more organized entities have already been doing it for many years. And even the Joint Commission has tried to move beyond the QA into CQI over the course of the last four or five years.

So I share with the comments that have been made so far that we should not back off of those. I think that would be going in the wrong direction. That's been hard to implement over a long period of time that successive change. Providers have gotten used to that, so I think it makes sense to keep going in that direction.

So my sense of both what we should be saying, and what we said yesterday, and what I hear the four people saying, is we want to be encouraging best practice. We want to encourage that, in part, by rewarding it. I think recommendation one, in my view, captures that better than recommendation two.

I don't like words like minimal and basic. First of all, it should be basic twice or minimal twice, but most people don't like to vote for minimal and quality. It scares people to just have minimal quality. They want a little higher threshold than minimal.

Whether one wants to use Joe's words from yesterday of

quality assurance, or whether that's too much technospeak, it probably is for most beneficiaries. They don't understand the difference between QA and CQI.

But my sense is more with recommendation one, reward for improvement. A sense of not backing off where we are already. On the other hand, as Joe has said, let's not mandate beyond that but reward and encourage beyond where we are right now. So I think one captures that better.

Again, the minimal wordsmithing I would do on one is some people don't like to talk about uneven quality. It scares them. So probably differential might be a better way of discussing that, rather than uneven. And then I think we should be making a bold statement about trying to really improve the quality of care in the basic Medicare program but understanding that that comes from voluntary efforts at this time, rather than through mandates.

DR. ROWE: So you'd take the second sentence of option two and add it to option one?

MR. MULLER: No. I happen to think one captures it reasonably -- the way I'm reading the second sentence of one and two, I'm reading them reasonably equivalent. I want to get rid of minimal and I want to get rid of moving backwards. Going forward should come through rewarding rather than through mandates.

DR. ROWE: That's what I'm looking for.

MR. HACKBARTH: Let me pick up on the compensation versus reward. To me, at least, compensation sounds exclusively like monetary payment. In an abstract sense maybe that's what you want to do, but I don't know how it could ever practically be done. Reward is more flexible and it could be we give them a seal of high quality that is then marketed to beneficiaries. Between those two words I would certainly prefer reward.

DR. ROWE: The problem is we don't want to reward them just for higher costs. We went to reward them for higher quality. So the wording here in one kind of suggests higher costs.

MR. HACKBARTH: So that's where you were going, take this sentence from number two and move it over.

DR. NEWHOUSE: Glenn, maybe we should drop the conditional of this and just say, Medicare should reward plans and providers who demonstrate superior quality, or something like that.

MR. HACKBARTH: And add that onto the end of option one?

DR. NEWHOUSE: Implied in the first sentence is that the capabilities are uneven. Why are we mentioning the first sentence if the capabilities are equal?

MR. MULLER: Joe, part of what we discussed at great length yesterday is a lot of these capabilities are still in process rather than outcome because of all of the arguments over why we can't measure outcomes very well right now. So we are still at a state where we want to reward innovation -- to use Alan's words -

- we want to reward innovation in quality improvement processes, which hopefully will lead to improvements in outcomes.

But I think most anybody concedes the evidence on that is hard to marshal at this point.

DR. NEWHOUSE: Indeed, I'm nervous that rewarding some dimensions, as I said yesterday, may result in give-ups on other dimensions that leaves us unbalanced and no better off. But that's an empirical issue.

MR. HACKBARTH: Let me see if I can crystallize where I think we are in terms of language in option one. What I hear people moving towards is something like the following. The first sentence as is, take into account the varying capabilities. And then --

DR. NELSON: Glenn, try and do it so we don't start out with a caveat. I'd like to start out with a strong statement that support quality improvement or quality assurance or both. We start out with a caveat that sort of says if.

DR. NEWHOUSE: What if the first sentence is Medicare should reward plans and providers that incur additional costs in QI efforts.

MS. RAPHAEL: The Secretary should apply quality improvement standards [inaudible].

DR. BRAUN: I'd really like to come back to Alan's original thing. I think I'm next on that list.

I really like the idea of differentiating between quality assurance and quality improvement. I think that's important. And option two really does that if we leave the first sentence in. And in the second sentence put Medicare should reward quality improvement efforts that exceed minimal requirements.

If we take the word voluntary out, then you could have it either voluntary or non-voluntary. At the moment, it's not voluntary for health plans. But I think it leaves us a little freer than just rewarding the voluntary ones, to reward either ones. But I think we want to reward quality improvement but we want to keep in place that there is quality assurance.

And it seems to me that we're heading for a goal of high quality and there are going to be different ways for different groups to get there, but at some point what now are basic quality requirements could be raised as we find ways that everybody can meet certain things.

DR. ROWE: Would you accept, Bea, getting rid of the word minimal and having standard requirements? That's one of Ralph's concerns, that minimal really sounds --

DR. BRAUN: Well, exceed requirements maybe. Again, if you take voluntary out, take minimal out so that we're allowing -- I mean, we're going to depend on how important they are.

MR. HACKBARTH: Bea, what about the reference in option one to varying capabilities? Remember that the question we were asked by Congress is should there be uniform requirements or

should we take into account varying capabilities. I know that's a paraphrase.

DR. BRAUN: I think, again, we're talking about two different things, if we're talking about quality improvement or quality assurance. And I think they keep getting mixed up. They keep getting mixed up in this chapter.

I think easily we could add that on to that first -- or put it first, taking into account capabilities of different providers and plans, all plans and providers should be required to meet basic quality requirements. That could be added on.

But I think there are basic quality requirements that should be met across the board regardless. And then the quality improvement standards will differ, depending on the ability of the providers.

MR. HACKBARTH: We need to get to a vote here.

MR. FEEZOR: Bea actually has raised a concern that I had. I think we're trying to play chess on three levels of the chessboard here. I think the quality assurance that Bea talks to, and I think that Joe talked about, is really more what we think ought to be available, information that ought to be available to all enrollee, all Medicare enrollees, sort of certain basics. I think if we think along that level, information that might go to the patient if you will, on some sort of quality assurance or accountability, then there is I think the issue of quality or accountability that is needed from Medicare as a purchaser, regardless of what venue.

And then there is perhaps a third sort of quality assurance that we try to get that is to CMS as a regulator to make sure that within the Medicare+Choice and some other arrangements that, in fact, there is at least assurances that some of the perversities of the incentives that might be within those plans do not occur.

So I think if we think along those lines, I think it leads us back to what Bea, and I think Joe, were talking about. We need to talk about some minimal level that may be constantly ratcheted up that goes for all enrollees, information on quality that helps them make decisions. And then that, in terms of the sort of quality improvement, which quite honestly many of our accrediting institutes that we referenced yesterday really are using, as Ralph said, because there are not good outcomes measurements. So we sort of say well, if you're making efforts towards quality improvements.

So I agree and I think taking the diverse starting points of providers and plans, the sentence, and perhaps some of Bea's comments, drafting that onto option two may get us a little closer to where I think we need to go.

MR. MULLER: Let me then suggest a combination of the two. That you take sentence one from option two. All plans and providers should be required to meet -- I'll leave the word basic

in -- quality requirements. And then you go to option one. The Secretary should take into account the varying capabilities. I think that varying capabilities concept is very important to have. And then if this results in a differential level of quality requirements, Medicare should reward -- to use Glenn's phrase -- plans and providers who -- we have to work on the syntax here because we don't want to reward people for additional costs. We want to reward people for quality efforts that may lead --

MR. HACKBARTH: Ralph, along those lines, if we're trying to make this distinction between basic quality assurance and quality improvement what we may want to do is make that explicit in the second sentence, which would be the carryover from option one. So we should say the Secretary should take into account varying capabilities when developing and applying improvement standards that go above these basic minimum requirements.

So we're making this contrast between sentence one and two.

DR. ROSS: Can I offer a caution here. Let's not try to cram it all into the recommendation. I think it's implied there that quality assurance for all, quality improvement where we can, taking into account varying capabilities, rewarding those who incur additional costs, meeting those [inaudible] additional steps.

MS. BURKE: I have a concern about reference to basically financing additional costs because we will create a new industry in finding additional costs. So I think the issue is not additional costs. The issue is rewarding effort. So I'd strike additional cost.

DR. REISCHAUER: This is my attempt to probably pack too much into one recommendation. All plans and providers should be required to meet basic quality assurance standards -- and then maybe or maybe not we could say -- that should be periodically strengthened, reflecting the various capabilities of different organizations. Medicare should reward plans and providers whose efforts to improve quality lead to significantly higher -- I don't want to say quality again. That's another aspect but we haven't talked about that at all. And we're using the word reward, so we aren't talking about cash necessarily.

MS. NEWPORT: We have a Rosenblatt proposal over here.

MS. ROSENBLATT: It's very similar to option two. Just adds a couple of words. All plans and providers should be required to meet basic quality requirements which take into account the capabilities of providers and plans. Medicare should reward plans and providers whose quality improvement efforts exceed requirements.

DR. REISCHAUER: What that says, Alice, whose efforts exceed quality improvement requirements or standards, or whatever you said. That's if you do more than is in the law now you should be

rewarded. I think the question was, in some sense, what's in the law now. It's reasonable to ask, the differential.

DR. ROWE: She has that in the first sentence. Read it again, Alice.

MS. ROSENBLATT: All plans and providers should be required to meet basic quality requirements which take into account the capabilities of providers and plans. Medicare should reward plans and providers --

DR. REISCHAUER: What you just said then would be the quality assurance could be different. That's Jack's --

DR. NELSON: What we're saying is that Medicare+Choice has a higher level of quality assurance currently under law than can be applied to traditional Medicare because they don't have the capacity to know what percentage of patients are having flu injections and so forth. The HEDIS requirements are different.

So the taking into account the capabilities of providers and plans has to be applied to the basic quality requirements, just as Alice recommends it.

Then there's the second. Because Congress originally asked us should the requirements that Medicare+Choice struggles under be also applied to traditional Medicare. And we say yes, if they have the capability. So that's where that qualifier has to be.

DR. REISCHAUER: Which we've said in the text.

DR. NELSON: But they may achieve it. So then the second sentence identifies the importance of continuing to try and improve that capability.

DR. STOWERS: Alan, I'd like to take it a step further. I still think that if we just took the first sentence out of option two, like Ralph is talking about, the first sentence out of option one. That way we are still saying that regardless of the type of plan, the Medicare beneficiary is going to be assured a basic level of care, regardless of what kind of plan they're in. And that we should take into account -- and I like it because it has quality improvement in it.

And then go back to the last sentence of option number two, reward plans and providers for efforts that exceed the minimum requirements.

So I think that way we still have a basic quality assurance for the entire program. We recognize different improvement standard ability, quality improvement capabilities, and there's a reward to doing that. So I think that would cover everything that we're talking about and still hold a high standard for the program.

DR. NEWHOUSE: I have two problems, the first of which Bob Reischauer did get around, which is the first sentence of one talks about quality improvement standards. I'm not sure there are quality improvement standards. There's various kinds of quality improvement efforts that go on. There's kind of minimal quality assurance standards, in my view, at least as I understand

this.

The second is I'm nervous about -- although I was the guy that introduced rewarding, I think, yesterday or the notion that it was an incentive rather than a requirement. I'm very concerned about rewarding just anything that happens to appear out there without having a clue about what it's buying us. Our language seems to allow for that.

That is to say, it seems to just reward anything that somebody labels as a quality improvement effort.

DR. ROWE: So you want something like, advances in the quality of care --

DR. NEWHOUSE: That can be demonstrated to achieve an important or worthwhile advance in the quality of care.

DR. ROWE: You want outcome, not process.

DR. NEWHOUSE: Well, if process -- if we know process links to outcome from other data, I'd be willing to buy process. I've just got to know that it's worth the money I'm spending to do this.

MS. BURKE: I just said to Ralph, this is just like sitting in a Ways and Means Finance Committee conference, just as circuitous. Brings back a lot of bad memories.

DR. ROSS: Let me offer one more unpalatable alternative. Given the circuitous discussion, which I don't see getting to closure here, that we bring this back to you in December. We have a statutory deadline that is prior to that, but I think we should be more concerned about getting to the right recommendation than in meeting a particular deadline. There's not a policy action immediately pending on receipt of this report.

MR. HACKBARTH: I think it's a little difficult, or it's a little difficult for me to follow the varying rewrites of this. I think we would benefit from having staff try to clean it up and come back with a specific proposal.

It might be worthwhile, though, Murray to try to do at least part of it on e-mail before the meeting, so that we don't have to sort of pick it up cold again at the next meeting. I would like to come back and be ready within five minutes to vote as the first two. Does that make sense to people?

DR. ROWE: Glenn, let me make a suggestion. I believe we are prisoner of our own process here, to some degree. We are trying to get several specific and different ideas and principles into a kind of two sentence recommendation. We may get there better if our colleagues are given some flexibility to write something which is a little more detailed and says with respect to the issue of quality in Medicare, the Commission identifies the following principles or something.

There are four or five ideas that are not that much in conflict that we just can't quite seem to get into this format that we're using. So we might try a little bit different format.

MR. HACKBARTH: I think it's worthwhile struggling with this one to try to find a consensus. I certainly wouldn't want to convey the message that I am uninterested in quality or I don't think that Medicare should be a leader in quality. So I'm really reticent to vote no. I take seriously what Sheila and others have said about backing off from current law.

So I think it's worth the struggle to see if we can come up with something that everybody can agree to.

Please, when you get the e-mail, if you will respond to that, probably the quicker we can do this while it's fresh in people's minds the better.

MR. MULLER: I'd like to make one brief comment on the rewarding or compensating. I don't think it should be reduced just to a kind of financial compensation issue. I think part of the discussion we had yesterday, at least Joe and I were pushing, was we want something that's more comparable with what came with the cardiac data in New York state which encouraged improvement of quality versus the kind of mortality data which caused everybody to say you don't know how to do risk adjustment and so forth.

So part of this is you want to have quality improvement processes, we want to be innovative of that and encourage people to improve the quality of care, as opposed to being penalized for doing so. So it's not just a cause issue. It's also people being scared of getting into these processes because they think the wrong message is being put forth.

That was really, I think, part of the sense that I hope doesn't get lost as you rewrite this.

DR. WAKEFIELD: I appreciate how difficult this must be, that this an end. I wasn't part of yesterday's discussion so maybe I'm coming fresh to it and I'm happy to have another three hours of discussion about this topic. I won't encourage that except to say that this comes down to me in sort of a personal way. And why I think it is important to do just what you're suggesting, Glenn, and try and get this as close to right as we think we can.

Using my own little 82-year-old mother, who's in fee-for-service, as an example of a Medicare beneficiary, we think about cost of quality improvement. I also think about the fact that she's had three different procedures in the last three years that our Medicare program has paid for. One, carpal tunnel surgery, first done on the wrong hand. Secondly, steroid injection, different provider, different hospital --

DR. ROWE: North Dakota?

DR. WAKEFIELD: I wouldn't say where, except I'll say this much -- no, not North Dakota.

[Laughter.]

DR. WAKEFIELD: And the second procedure, a steroid injection under fluoro in an outpatient department, wrong hip.

There's a lot that we've got to -- and Medicare paid twice for two different procedures.

So true enough, we may not be able to quantify right now what it is a QI brings to us, but I can sure quantify what happens when we don't have systems of care in place. And I'll be very strong to say I'm not talking about poor providers. I'm talking about systems of care that could have been in place and preventing both of those things from happening.

So it's a really important struggle. She's just an n of one, but I wouldn't wish it on anybody else. So I'm glad we're going to come back to this one more time.

MR. HACKBARTH: That's a good concluding note.

DR. ROWE: Glenn, I'd like to comment on this. Let me just pass this around, if I might.

MR. HACKBARTH: Sheila is raising an important point. We did have other recommendations in this particular report. My recollection was that there was not much controversy about them. We probably ought to handle them all as a package when we vote, and not do it separately.

MS. MILGATE: There's some link between how we do one and the back of it, so that's probably good.

MR. HACKBARTH: Okay, Jack, do you want to describe the piece that you passed out?

DR. ROWE: I mentioned yesterday that there hadn't been much in the way of activity from the plan sponsors with respect to requiring quality or paying for quality. This article by Mil Freudenheim appeared in today's New York Times describing a consortium of sponsors in Florida, Lockheed-Martin, Walt Disney World and Universal Studios, who are going to reward doctors and hospitals presumably based on their compliance with AHRQ standards for treating certain diseases.

This is very encouraging. These are obviously self-funded plans that are doing this. And it notes something else that is being done in New York with Empire Blue Cross and a number of large sponsors.

Alice mentioned something about Wellpoint recently had a lot o press. And there have been other -- US Healthcare years ago actually started doing this in Philadelphia. So there are a number of different initiatives but this is encouraging that it's happening now and maybe there will be more like this.

Having said that there wasn't much of this, I wanted to bring this to people's attention. Thank you.

MR. HACKBARTH: Thanks, Jack. Thank you, Mary and Karen.